10 – Preauthorization

Overview

Definitions

Preauthorization is the determination of the medical necessity and appropriateness of treatment as a required part of the Utilization Management process for certain covered services. Preauthorization may also be referred to as prior authorization, prior approval or precertification. Failure to obtain these proper permissions may affect claim payment, subject to the terms and conditions of a Coverage Plan. A preauthorization is not a guarantee of benefits or payment.

Predetermination is a voluntary, written request for review of treatment or services and includes services that may be considered not medically necessary; investigational, experimental or unproven; or cosmetic. Predetermination approvals and denials are usually based on provisions in our medical policies. A predetermination of benefits is not a substitute for a precertification.

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10.1 Obtaining Preauthorization

For preauthorization, complete the Preauthorization Request form located in the attachments at the end of this section, and in the Forms section on our website. This form will provide us with the necessary information in order to process requests in a shorter period of time.

- Preauthorization may also be requested by calling the preauthorization phone number listed on the back of the member’s ID card.
- If you are faxing or mailing in a request, please submit the completed form along with your supporting documentation.
- Behavioral health services, authorizations, benefits and eligibility information must be obtained by calling 888-898-0070. For further information see Section 12, Behavioral Health Services, and on our website under the Clinical Resources tab.
- iExchange may also be used for any inpatient or outpatient requests. This is an online precertification and concurrent review tool that allows facilities and admitting physicians to request, view, extend, and ultimately manage cases in real time. This free functionality does not require any additional software.

The Medical Management (MM) department will:
- evaluate the appropriateness of the admission and level of care using Milliman criteria and medical policy as indicated,
- certify a projected length of stay, and
- assign a reference number.

MM personnel will respond within 5 business days of receiving the request (within 72 hours for urgent care requests).

Most BCBSNM plans exclude reimbursement for services or do not allow for reimbursement where preauthorization is required and has not been obtained. To ensure reimbursement, providers and members must comply with the member’s benefit plan requirements for preauthorization.

**Note:** Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment of a particular service, that authorization applies only to the medical necessity of treatment. **All services are subject to benefit limitations and exclusions.**
10.1 Obtaining Preauthorization, Continued

Medicaid and Medicare Requirements

Medicaid Preauthorization Requirements – Refer to the Blue Cross Community CentennialSM section.

Medicare Preauthorization Requirements – Refer to the Blue Cross Medicare AdvantageSM section.

Members using Network Facilities

HMO and EPO BCBSNM members must select a hospital within the network of contracted BCBSNM facilities. BCBSNM PPO members using network hospitals will receive a higher benefit level than they would if services were rendered in an out-of-network hospital.

If the attending physician has privileges at more than one BCBSNM contracted facility, Customer Service can provide information regarding the most cost-effective facility so the member’s out-of-pocket expenses are minimized.

Requests for Out-of-Network Providers

Requests for out-of-network provider services for HMO members require preauthorization. If not obtained, the out-of-network service will not be covered. If you believe the member needs the services of an out-of-network provider, the Medical Director must review and approve these requests before services are scheduled or rendered.

These out-of-network requests will only be considered in the following circumstances:

- An emergency situation makes the use of an out-of-network provider necessary.
- No participating provider within the BCBSNM network can provide the service needed.

Authorizations for out-of-network providers based on “non-availability of services” may require that an in-network specialist who treats the condition in question document that such service is not available within the contracted network.
10.2 Services Requiring Preauthorization

The attending physician must obtain preauthorization for the services listed below (if covered by the member’s plan), except in an emergency. (Excludes FEP and other groups that may have selected additional preauthorization requirements not specified in this document)

- All inpatient medical/surgical admissions – acute care, rehabilitation, skilled nursing facility, long term care facility, and hospice
- All behavioral health/chemical dependency admissions (Refer to Section 12 – Behavioral Health Services);
- Air ambulance
- Transplants
- Select pharmacy requests (Refer to Section 14 – Pharmacy Services)
- Autism treatment – treatment plan is required for Applied Behavioral Analysis (ABA), physical, speech and occupational therapies
- Requests for out-of-network provider services for HMO members

Length of Stay

If an extension of the initial length of stay is necessary, call the Medical Management department at 1-800-325-8334 before the initial approved length of stay expires. Failure to obtain approval for length of stay beyond that which has been approved may result in reduced payment to the member and/or provider.
10.3 Emergency Care

Emergency services to screen and stabilize the patient are a benefit without prior approval. Since prudent layperson conditions are in effect, the patient may use 911 or emergency room services if they believe a medical emergency exists.

10.4 Urgent Care

When medically necessary care is provided to the patient in an urgent care facility for an illness or accidental injury, no preauthorization is required.
10.5 Obtaining Predetermination

**Requesting Predetermination**

For predeterminations, complete the [Predetermination Request form](#). The predetermination process gives you the opportunity to confirm coverage in writing before the requested service is rendered.

Requests for benefit determination can be obtained by submitting a predetermination request. Examples of predeterminations include:

- outpatient services
- durable medical equipment
- surgeries that might be considered cosmetic
- possible experimental and investigational procedures/treatments

**Important Tips**

- **Always** check benefits before submitting a predetermination. A predetermination is not available for all procedures. A predetermination may not be available for complete or partial bony impacted teeth.
- Fill out the entire Predetermination Request form.
- Include provider/facility name, address, fax and phone numbers.
- Include ordering physician name, address, fax and phone numbers.
- Provide contact name, address, fax and phone numbers.
- Always provide procedure code(s) and diagnosis code(s).
- If applicable, provide left, right or bilateral.
- Regarding major diagnostic tests, please include the patient’s history, physical and any prior testing information.
- If indicated, include original photos or digital color copies that clearly show the affected area of the body. This information must be mailed to the address indicated on the Predetermination Request form.
10.6 Attachments

- Preauthorization Request Form
- Predetermination Request Form